2011 - 2012 Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information. ***PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD* Information about the person to receive vaccine** (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:* DEDHAM	State: * MA	Zip:* 02026	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * ____ ____ ____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:* Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

*** I give permission for my child to be vaccinated. ***

X _____ Date: _____

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For Clinic/Office Use Only:

Date vax given:	Vax Type	Vax Manufacturer	Exp. Date/ Lot No	Dose	State Supplied	Preserv Free	Injection Site (Circle)	Route (Circle)	Date On VIS	Date VIS given
	Flu	Sanofi Pastuer	UH 471AA 06//30/12	0.5 ml	Yes	Yes	Intramuscular	R Arm L Arm R Leg L Leg		
					Yes No	N/A	Intramuscular Subcutaneous	R Arm L Arm R Leg L Leg		

Clinic Site Name: DEDHAM BOARD OF HEALTH MDPH Provider PIN#: 10349 Clinic Address: 26 BRYANT ST

DEDHAM, MA 02026 781-751-9224 Signature of Vaccine Administrator: _____ Date: _____

2011 - 2012 Insurance Information Form

Release of Claims, Indemnity and Hold Harmless Agreement

I, _____, being 18 years of age or older, in consideration of my participation in the Town of Dedham's public health flu vaccine program as a receipt of Influenza Vaccine and/or Pneumococcal vaccine, and for other good and valuable consideration hereby acknowledged, do hereby agree in behalf of myself, my heirs, and personal representatives, to forever RELEASE the Town of Dedham, Massachusetts, and their successors, assigns, employees, agents, staff, officers, volunteers, and contractors (the "Releases"), from any and all claims, actions, rights of action, and causes of action, liability, damages, costs, loss of services, expenses, compensation and attorneys' fees, however arising, as a direct or indirect consequence of the administration of such vaccine.

I further acknowledge that my participation in such public health flu vaccine program is voluntary and may expose me to the risks of such vaccine. I therefore also promise, to INDEMNIFY, REIMBURSE, DEFEND, and HOLD HARMLESS the Releasees against any and all legal claims and proceedings of any description including damages, costs and attorneys' fees however arising as a direct or indirect consequence of my participation in such program.

I hereby further covenant for myself, my successors, assigns, heirs and personal representatives not to sue the said Releasees on account of any such, claim, demand or liability.

I am fully aware that by signing this document I am releasing the above mentioned parties from liability that may arise as a result of international or negligent acts of these parties.

Witness my hand and seal this _____ day of _____ in the year _____.

Name (Printed)

_____

Signature

NOTE YOU MUST BE 18 YEARS OF AGE OR OLDER TO PARTICIPATE IN THIS PROGRAM.

_____

Signature

_____

Witness

THIS FORM NAY NOT BE ALTERED